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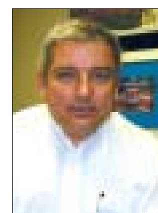
Use of Technology in the Delivery of MTMS and CCIP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That's right. There's a whole new set of acronyms that are associated with the Medicare Modernization Act (MMA). The main ones we will deal with here are medication therapy management services (MTMS) and chronic care improvement programs (CCIP). There are certain provisions for prescription drug discount cards and some formulas for Medicare patient participation in copayment that are already in effect, and more are on the way. We will skip over those in an attempt to prepare you for an exciting opportunity that should begin in 2006. Of course, there are other acronyms to learn. Payment for services rendered by pharmacists will be reimbursed by prescription drug programs (PDP) under the guidance of the Centers for Medicare and Medicaid Services (CMS) (Figure 1). For the purposes of this program, the country has been divided into 10 regions. For example, Alabama and Tennessee were combined into one region. The goals of reimbursement for providing these services include the optimization of therapeutic outcomes, improvement of medication use, and reduction of risks, such as adverse drug reactions, in the Medicare population.

A New Opportunity

Pharmacists will be on the front lines of both explaining the complicated provisions of the new act and helping patients enroll in the programs. Services rendered by pharmacists should include increased drug adherence, improved enrollee knowledge of their own conditions and treatments, and reduced overuse and underuse of drugs. We are particularly excited about this program because it represents the arrival of the reimbursement that pharmacists have been seeking for the provision of cognitive services. With no significant increases on the horizon for distributive-services reimbursement levels, this new set of regulations should be a tremendous opportunity to move the profession in a more patient-focused direction. Fortunately, the pioneers who worked out the cognitive-service provision in the past and the umbrella of pharmaceutical care created the philosophical and operational underpinnings for this new provision of services.

The diseases to be focused on center around congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), uncontrolled diabetes, and other associated comorbidities, such as hypertension and asthma. Patients who use numerous medications and who have several of the targeted diseases will be identified for both medication therapy management and chronic care improvement under the new law. While there is overlap between the two program areas, it is generally understood that medication therapy management will occur primarily through pharmacist intervention and that chronic care improvement will involve disease management companies. These disease management companies will require a network of service providers to man-

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age the requirements of interventions needing face-to-face encounters. For this reason, pharmacy organizations should be approaching the organizations who are awarded chronic care improvement opportunities pilot projects with an offer of collaborative assistance. Another player named in the new regulation is the group of quality improvement organizations (QIOs) that will be funded to provide evidence-based approaches to providers and oversee the assessment and interpretation of population-based outcomes.

The range of services that pharmacists can expect to provide would start with the assessment of patients' health status. Depending on the state-level pharmacy practice act governing the profession, these services can be performed by the pharmacist acting alone as a primary care practitioner and/or through a collaborative arrangement with physicians. Obvious areas for service provision include the formulation of drug treatment plans to maximize therapeutic outcomes and management of high-cost specialty medications. A major responsibility will be providing education and training to at-risk patients. Another service that pharmacists will be expected to provide is evaluating and monitoring patients' responses to drug therapy while identifying, preventing, and resolving drug-related problems.

Figure 1. CMS's web site has a good deal of information about the Medicare Prescription Drug, Improvement and Modernization Act of 2003. (Source: http://www.cms.hhs.gov/medicarereform/.)

The Technology Connection

With the above as a background, how can we expect technology to support the provision of services in a way that allows pharmacies to receive a reasonable return on investment from their efforts? We propose that pharmacy management software vendors continue to be the controlling hub for the rendering of these services. We further propose that the signaling by a pharmacist that a patient is eligible to receive services be the beginning step in the process. Linking resources to the workflow of a busy distribution pharmacy will be essential for pharmacists to efficiently and effectively deliver medication therapy management services. Some of the services may need to be provided in the pharmacy. Others could be provided by a call center or through web-based Internet connectivity when appropriate.

New procedural billing codes are being proposed to the American Medical Association's Current Procedural Terminology Editorial Panel. This initiative is being led by the Pharmacist Services Technical Advisory Coalition (PSTAC), a coalition of every pharmacy association in the country. Once approved, these codes can be used on the CMS paper 1500 form or billed electronically using the *X12N 837 Companion Guide* developed by NCPA for billing services performed by pharmacists. Billing for services will be distinctly different from billing for dispensing fees. Copayments are not allowed with service fees, and all fee levels will be based on the time and resources used to provide the services for which the pharmacist is billing. Fees will be negotiated regionally with prescription drug plans. CMS will oversee the whole process to ensure fair reimbursement. It has been suggested that seven billing codes will be needed. Three of these codes will be used for different intensities of initial encounters performed by pharmacists. Another three codes will be used for billing for the provision of follow-up procedures. The final code will reimburse group activity performed by pharmacists on behalf of CMS.

The Need to Act

We have asked the profession for years to publish a list of requirements that software vendors can use to prioritize their application enhancement priorities. Now this list is available. This situation has been a perfect example of such a document being needed by both the profession and the industry. Our biggest fear is that the opportunity offered to the profession by the proposed regulation will not receive the kind of response that makes a significant difference in the lives of older patients. We hope that pharmacy will not create an environment in which another profession steps up into pharmacy's place. We are certain that the talent exists to respond to this opportunity. We can't conceive of a scenario that doesn't use an array of techno-

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logical resources to achieve efficiency and effectiveness to incorporate these new services into the workflow of a pharmacy operation. But software vendors must also provide the PSTAC's 837 electronic billing transaction so that service claims can be billed using a HIPAA-authorized transaction set.

Interestingly, many software vendors have already invested in the level of documentation that will be required in this type of service provision. We have identified over 160 different technological interventions that can be used to address medication adherence problems. There are hundreds of resources — in the form of guidelines, outcome-measuring technologies, telecommunication options, and multimedia educational resources — that can be integrated into the service provision for any pharmacists who chooses to participate. For example, a resource on www.mercksource.com presents three-dimensional animated video clips that can be used to help explain how a disease works in the human body and how treatments can make a difference in the quality of life for patients. These resources are sitting on the Internet today as a "virtual body tour" and are free of charge (Figure 2).

Allocating Resources

The technological systems that will support the provision of MTMS will vary according to the model used by an individual pharmacy. In some pharmacy settings, pharmacists will schedule a floater pharmacist to relieve them to provide MTMS. For example, patients who are eligible could meet with a pharmacist on Wednesday afternoons. An additional pharmacist could be scheduled to relieve the service provider from distribution duties. Other pharmacies may elect to have the floater pharmacist be the person who provides the clinical services. Some pharmacists may hire nurses and/or additional pharmacists to set up an integrated practice within the pharmacy to handle MTMS. Other pharmacists may rent floor space to a separate clinical practice that will be housed within the pharmacy.

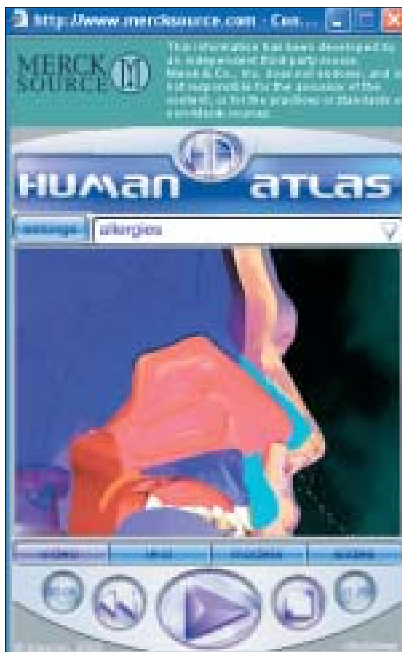

Figure 2. Merck's virtual body tour (here showing allergies) can be used to educate patients about their condition. (Source: http://www.mercksource.com/pp/us/cns/cns_interactive_tools_vap_index.jsp.)

We also see specialty clinics staffed by pharmacists being formed for provision of services even where no dispensing activities will take place. Some pharmacy chains will train specialists in the provision of services within a given city and refer patients to nearby chain pharmacies for service. Larger operations will use a combination of in-store and central call centers to provide services that are appropriate to each setting. We also see that home care services could become a part of the service provision.

We believe the new opportunity offered to the profession by CMS regulation should be addressed by the end of the second quarter in 2005. We think that states that are combined into service regions should develop business models to use in proposing policies and guidelines for the rendering of services. In scanning the available technological resources, we are confident that the technology support needed to provide these services well not only exists but is very much available. We call on pharmacy professional organizations to specify application requirements for the pharmacy IT industry to use in assisting the profession to achieve its goals in this area. We are both ready to assist in this process as needed. These are our thoughts — we welcome yours. **CT**

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